

Connecticut Transformation State Incentive Grant

Workforce Transformation Workgroup

Report of Recommendations

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Executive Summary

There is broad consensus that strengthening Connecticut's behavioral health workforce must be a critical element in efforts to transform the state's system of mental healthcare. The workforce is the principal "infrastructure" through which access to care is provided and effectiveness of care is assured. Multiple and compelling problems regarding this workforce span issues related to workforce composition, recruitment, retention, training, education, and the sustained adoption of newly learned skills and best practices. A concerted agenda is required to address these problems systematically.

To formulate an action plan for strengthening the workforce, the leadership of Connecticut's Transformation State Incentive Grant (T-SIG) convened a Workforce Transformation Workgroup comprised of 30 individuals representing persons in recovery, family members, advocates, state agencies, private non-profit providers, educators, researchers, and workforce experts. This workgroup met eight times over a four month period, collecting and reviewing information on the state's workforce and generating a set of recommendations to be considered by the Oversight Committee for this grant.

The data sources for this process included: (1) workforce issues and recommendations identified in state agency reports over the past five years; (2) information and expertise provided by workgroup members; (3) specially convened planning sessions (on children, youth, and families; the interface between higher education and behavioral health; and on-line learning); and (4) over 40 focus groups on workforce needs, resources, and recommendations conducted by workgroup members with diverse stakeholders across the state. The recurrent themes from these focus

groups were summarized in a preliminary report of findings that informed the selection of recommendations.

The workgroup adopted a broad definition of “workforce” that included: those specifically trained and employed to provide mental healthcare; all state employees; other health and human service providers; and consumers and family members. The latter play an enormous and, too often, unrecognized role in caring for themselves and others. Persons in recovery and parents made major contributions to this planning process as workgroup members, paid staff to the workgroup, and participants in the day-long retreat on workforce needs for children, youth, and families.

The Workforce Transformation Workgroup identified a broad range of problems and issues, distilling from these a set of nine priority recommendations for inclusion in the Comprehensive Mental Health Plan that is the principal product of the Transformation State Incentive Grant (see the *List of Recommendations* that follows this Executive Summary).

The workgroup calls for the establishment of a **Behavioral Health Workforce Collaborative** and **Centers for Excellence** to sustain workforce planning, implement interventions, and leverage resources beyond those captured through this grant. It recommends **enhanced workforce roles for consumers and family members**, an **informational campaign on careers and jobs** in behavioral health, and targeted incentives to **recruit culturally and linguistically diverse individuals** into this field. Additional recommendations include **competency and curriculum development** efforts to build a workforce skilled in caring for children, youth, and

families; and enhanced “**basic training**” targeted to the direct care, paraprofessional workforce in behavioral health and to other health and human service personnel who so often respond to the needs of persons with mental health and behavioral/emotional problems. Enhanced opportunities for **on-line learning** and **supervision** regarding the provision of care are further recommendations designed to support the workforce.

Transforming the infrastructure, composition, and competencies of the behavioral health workforce is fundamental to the transformation of mental healthcare in Connecticut. The recommendations provided by the Workforce Transformation Workgroup constitute a starting point for addressing this critical agenda. A sustained effort to recruit, retain, train, supervise and support its behavioral health workforce must be foremost among the state’s priorities, as it strives to improve access to compassionate and effective care.

List of Recommendations

Recommendation 1: Establish the *Connecticut Behavioral Health Workforce Collaborative* as a permanent body charged with planning, coordinating, and implementing interventions to strengthen the workforce.

Recommendation 2: Increase the number and percentage of persons in recovery and family members employed at all levels in state agencies and private, non-profit behavioral health organizations.

Recommendation 3: Increase recruitment by implementing an informational campaign that highlights career and job opportunities in behavioral health.

Recommendation 4: Increase scholarships, training stipends, and other incentives to support the recruitment and retention of culturally and linguistically diverse individuals in the workforce.

Recommendation 5: Develop a workforce skilled in caring for children, youth, and families by identifying core competencies and implementing competency-based curricula focused on the needs of these individuals.

Recommendation 6: Develop and deliver recovery-oriented, culturally informed, and gender responsive training on mental illness and co-occurring disorders to (a) direct care, paraprofessional personnel in the behavioral health system; and (b) other health and human service personnel who are not part of the specialty behavioral health workforce.

Recommendation 7: Implement a system to provide web-based training to the specialty workforce, other health and human service personnel, persons in recovery, children, youth, and families.

Recommendation 8: Ensure that all members of the workforce receive high quality supervision in accord with a common set of standards from individuals trained in competency-based supervision.

Recommendation 9: Develop “Centers for Excellence” in behavioral health workforce practices. This initiative will begin in the child and youth behavioral health arena and subsequently be expanded to encompass youth in transition to adulthood, adult persons in recovery, and older adults.

Introduction

In gathering information about the state of mental healthcare in America, The President's New Freedom Commission on Mental Health (2003) found evidence of diverse and substantial concerns about the behavioral health workforce.

The Commission heard consistent testimony from consumers, families, advocates, and public and private providers about the “workforce crisis” in mental health care. Today not only is there a shortage of providers, but those providers who are available are not trained in evidence-based and other innovative practices. This lack of education, training, or supervision leads to a workforce that is ill-equipped to use the latest breakthroughs in modern medicine.

(President's New Freedom Commission, 2003, p. 70)

In its final report, the Commission recognized that workforce development was an essential element of sustainable reform and a critical vehicle for achieving the transformation of current systems of care.

There are many reasons to believe that the State of Connecticut is facing a workforce crisis similar to that described by the New Freedom Commission. Provider agencies report major difficulties in recruiting and retaining qualified employees, particularly in the private, non-profit sector. There is a critical shortage of personnel trained and skilled in caring for special populations, such as children, youth, young adults, and elderly persons. In terms of culture and language, the current workforce is far less diverse than the population it serves, raising concerns about the ability of the existing workforce to provide culturally relevant services. Pre-service and continuing education systems have had difficulty keeping pace with rapid changes in healthcare delivery. There is particular concern that resilience and recovery-oriented approaches to care and shared decision-making approaches with the recipients of services are not adequately taught in our training systems.

The State of Connecticut, in its application for the federally funded Transformation State Incentive Grant (T-SIG), identified workforce planning objectives in its proposed process for developing a comprehensive state mental health plan. These objectives included assessing the knowledge and training of the current workforce, its capacity and its needs for transformation to a recovery-oriented system of care, and the perceptions of workforce needs by multiple stakeholders. To address these workforce objectives, Connecticut created a *Workforce Transformation Workgroup* as one of seven groups that has conducted planning as part of this grant.

The Workforce Transformation Workgroup has been comprised of 30 members representing diverse backgrounds and perspectives. It has met and worked intensively over the past five months to gather and review information from multiple sources in an effort to define the current status and needs of the workforce. It generated over 25 specific recommendations and narrowed these to a final set of nine that are presented in this report for consideration by the Oversight Committee of the grant. The Oversight Committee will select the recommendations to be included in Connecticut's comprehensive mental health plan to be submitted to the federal Substance Abuse and Mental Health Services Administration. This document provides an overview of the planning process for the Workforce Transformation Workgroup and presents and describes its final recommendations.

Composition of the Planning Workgroup

Membership selection for the Workforce Transformation Workgroup was managed by T-SIG staff, in consultation with the Convener of the workgroup. T-SIG staff extended multiple widely distributed invitations to state agencies, non-profit organizations, advocacy groups, and other interested parties to nominate members to each of the seven workgroups organized under this grant to manage the planning process. All individuals nominated to serve on the workforce workgroup were invited to serve and each had a strong interest in workforce issues.

The total membership grew during the first two months of planning, culminating in a total of 30 individuals representing managers within state agencies and private non-profit provider organizations, as well as persons in recovery and family members¹. Specifically, the state agencies represented in the workgroup included the Department of Administrative Services (DAS), Department of Children and Families (DCF), Department of Corrections (DOC), Department of Mental Health and Addiction Services (DMHAS), Department of Labor (DOL), Department of Public Health (DPH), Department of Higher Education (DHE), and the Department of Veteran Affairs (DVA). In addition, Court Support Services Division (CSSD) represented the Connecticut Judicial Branch on this workgroup. DMHAS clinical facilities and departments represented on the workgroup included the Capitol Region Mental Health Center, the Southwest Connecticut Mental Health System, the Education and Training Division, the Workforce Development Unit, and Co-occurring Disorders Systems Incentive grant. The non-profit agencies represented included Community Health Resources, Intercommunity Mental

¹ The Workforce Transformation Workgroup recognizes that there are variations in language used to refer to individuals across the lifespan who are living with emotional and behavioral problems, mental illnesses, and co-occurring mental and addictive disorders. Similarly there are differences in language across the lifespan regarding the preferred terms for health and wellness. The importance of lifespan issues and the concepts of resilience and recovery are conveyed both implicitly and explicitly throughout this report.

Health Group, Catholic Charities, and Wheeler Clinic. Families were included via NAMI-CT representation. The persons in recovery who participated were affiliated with Focus On Recovery- United (FOR-U), the Yale Program on Recovery and Community Health, the Connecticut Mental Health Center, the DMHAHS Education and Training Division, and the Southeast Mental Health Authority.

The workgroup Convener was Michael Hoge, Ph.D. of the Yale University School of Medicine Department of Psychiatry. To staff the workforce planning process, Dr. Hoge assembled a team that included experts on recruitment and retention, cultural competence, evidence-based practice, and supervision. Jessica Wolf, Ph.D. served as a member of this team, contributing her expertise on training and education. Frank Gregory, Ph.D., representing DCF, worked closely with the team and led a special retreat focused on workforce issues related to the care of children and families. Two staff persons from the Yale Program on Recovery and Community Health (PRCH) served as workgroup members and the Assistant to the Chairperson for the T-SIG, Barbara Bugella, M.S.N., M.B.A., participated in selected workgroup meetings.

Defining “Workforce”

Traditionally, the mental health workforce is defined to include those specifically trained and employed to provide prevention and treatment services to persons with mental health problems or illnesses. However, this definition is overly narrow as it excludes the many health and human service providers from whom persons with mental illnesses routinely seek help and it excludes persons with mental health problems and their families, who care for themselves and provide care and support to each other.

Therefore, the leadership of the T-SIG and the Workforce Transformation Workgroup collaborated in adopting a very broad definition of “workforce” that includes *all* those who care for individuals with mental health problems or illnesses. Four specific categories within this workforce were identified:

- Persons in recovery, children/youth with emotional and behavioral difficulties, and the families of these individuals;
- The behavioral health workforce, specifically trained to provide prevention and treatment services to persons with mental health problems or illnesses;
- Employees within state agencies who are not part of the specialty behavioral health workforce, but are often called on to assist individuals with mental health problems and illnesses;
- Other health, human service, and educational providers.

Workgroup Process

The workgroup was convened for the first time on January 13, 2006 and met eight times through May 22, which was its last formal planning meeting (one meeting was held via conference call). At the initial meeting, members were oriented to the Transformation State Incentive Grant and the charge to the Workforce Transformation Workgroup, which was to identify workforce needs, generate recommendations to meet those needs, and identify any resources in Connecticut, such as prior or existing workforce development efforts, that could support implementation of the recommendations.

A detailed work plan for the workgroup was developed, revised, and finalized during the first few meetings. In addition to formalizing the definition of workforce, as described above, the workgroup recommended additional members and sharpened its planning focus on two key areas: (1) recruitment and retention, and (2) education, training, and the sustained adoption of new practices.

Workgroup members identified their principal workforce concerns early in the process. Dr. Manuel Paris presented a summary of workforce issues and action strategies in other states and Dr. Hoge provided a progress report on the SAMHSA-sponsored development of a national strategic plan on behavioral health workforce development by the Annapolis Coalition. Dr. Maria O'Connell presented a verbal and written summary of work by PRCH to review all reports relevant to mental health generated by state agencies and task forces in Connecticut over the past five years. Implications from these reports for workforce planning were distilled and highlighted for members of the workforce workgroup.

To assess the current status of workforce issues in Connecticut, focus groups were then conducted with key stakeholders throughout the state to obtain their diverse perspectives on workforce needs, recommendations, and resources. Workgroup members, assisted by their staff, took responsibility for organizing and facilitating over 40 focus groups involving hundreds of participants. A semi-structured focus group interview format, instruction sheet, participant handout, and report form were developed by staff to ensure relative uniformity in the process. Summaries of each focus group, plus detailed analyses of the focus group findings, are contained in the *Preliminary Report of Needs, Recommendations, and Resources*, dated June 1, 2006.

Stakeholders participating in the focus groups included, but were not limited to the following: adult persons in recovery; family members; inmates in a women's correctional center; veterans; state agency managers and staff; program and agency directors and staff in private non-profit provider organizations; supervisors; direct care staff; educators and trainers; directors of training from Connecticut's state agencies; human resources personnel; students in behavioral health training programs; advisory board members; and advocacy group members.

To ensure that the planning process adequately addressed issues germane to the life span, a special day-long retreat was organized focused on workforce needs related to the care of infants, children, youth, young adults, and their families. Dr. Frank Gregory of DCF, working with the workgroup Convener, Michael Hoge, organized and hosted this planning session, which opened with overview presentations by senior leadership of DCF, DMHAS, and the T-SIG. This was followed by a keynote and facilitated discussion on workforce issues and innovations nationally, presented by Dr. Larke Huang, the Senior Advisor on Children at SAMHSA and a member of the President's New Freedom Commission. The participants in this planning retreat comprised a diverse set of stakeholders in child health, including primary care providers and educators, with parents constituting 25% of attendees. These participants conducted planning in two breakout groups, each of which generated a set of workforce recommendations germane to the care of children and families.

Several additional special planning sessions were held as part of this process. The representative from the Department of Higher Education to the Workforce Transformation Workgroup

organized a planning meeting with senior leadership from Connecticut's public and private colleges and universities. This session was attended by the Convener of the workgroup and by the Assistant to the Chairperson for the T-SIG. Discussions focused on the existing and potential relationships between higher education and the behavioral health system, as well as the mechanisms in Connecticut for the provision of distance learning.

A second special planning meeting was organized by Richard Fisher, M.S.W., Director of Education and Training at DMHAS. This meeting was convened with a representative of the Department of Information Technology (DOIT) to discuss the status of planning for a platform and development process for distance learning that would be accessible to Connecticut agencies and their grantees.

Dr. Jessica Wolf invited feedback on workforce issues from participants at a statewide conference on young adults. Organized by the North Central Regional Mental Health Board, the conference was titled "Turning 18: Issues Before and After Transition", and was attended by over 300 young people, parents, and service providers.

Special presentations also occurred during scheduled meetings of the Workforce Transformation Workgroup. The Department of Labor presented on web-based efforts that it conducted to enhance workforce recruitment for the Department of Mental Retardation and its grantees. Dr. Hoge demonstrated several websites relevant to knowledge dissemination and workforce development in behavioral health (Network of Care at <http://www.networkofcare.org>; Mental

Health Education Workforce Collaborative at www.mhewc.org; and the Mental Health Workforce & Education Exchange at www.mhwee.org).

After all information was gathered, the workgroup staff generated a list of 23 potential recommendations for consideration. Members of the workgroup met to review and revise these recommendations. Staff members then integrated, condensed, and eliminated recommendations in an effort to arrive at a reasonable number for presentation to the Oversight Committee. The workgroup met to consider nine final recommendations that were accepted, with substantial revisions. Any workgroup recommendations selected by the Oversight Committee for potential inclusion in the Comprehensive Mental Health Plan to be submitted to SAMHSA will be further developed in terms of implementation steps, timelines, and proposed budgets.

Role of Persons in Recovery and Families in the Process

Persons in recovery and families were involved at all steps of the workgroup's efforts, including: participating as members of the workgroup; designing the focus group guidelines; conducting and participating in focus groups; and developing the recommendations. An effort was made early in this planning process to expand membership of persons in recovery and family members in the workgroup. A discussion of barriers to participation led the workgroup to recommend that T-SIG managers implement a system of stipends to support consumer and family member participation. Such a system was, in fact, put into place. For the retreat on child workforce issues, an objective was set and met that 25% of all participants would be parents or other family members. A person in recovery was hired using T-SIG funds to serve as a member of the workforce workgroup staff. She consulted on the design of the focus group materials and

organized and conducted six focus groups of persons in recovery. The focus group questions were also adapted into a brief written survey that was included in the NAMI-CT newsletter and distributed to all NAMI-CT members. All Workforce Transformation Workgroup recommendations have been carefully reviewed and structured to maximize the involvement of and impact on adult persons in recovery, children, youth, and families.

Detailed Recommendations

Recommendation 1: Establish the *Connecticut Behavioral Health Workforce Collaborative* as a permanent body charged with planning, coordinating, and implementing interventions to strengthen the workforce.

Need Addressed

An extremely large number of workforce problems face the behavioral health system in the State of Connecticut. The detailed analysis of the stakeholder focus group findings produced a bulleted, single-spaced list of needs and recommendations that was 33 pages in length. These recommendations address diverse aspects of problems related to recruitment, retention, training, education, and the sustained adoption of best practices by the workforce. The needs and recommendations relate to workforce needs to serve diverse populations across the lifespan and a wide range of clinical and social problems.

The Workforce Transformation Workgroup reached two critical conclusions related to the scope of the issues and the State's response to these problems. First, funds available through the Transformation State Incentive Grant can be helpful in addressing *some* of these problems, but clearly only a minority. A critical element of the State's effort to transform the workforce must

be, therefore, to ensure that a structure and process exist that can leverage *existing* resources so that there is a broad and ongoing response to the many workforce issues that call for attention.

A second conclusion was that no structure currently exists for sustained and coordinated planning around workforce issues. The Workforce Transformation Workgroup brought together diverse stakeholders in a productive effort to assess workforce problems and devise recommendations. Many of the stakeholders had not previously collaborated on this agenda and the workgroup filled a unique need in the State for workforce planning.

In light of these observations, the Workforce Transformation Workgroup strongly recommends the creation of a permanent *Behavioral Health Workforce Collaborative* responsible for sustained planning, coordination, and implementation of efforts to strengthen the workforce. Such “collaboratives” have been implemented in several other locales and have been used successfully to create a proactive workforce development agenda. The original and most developed collaborative is the San Francisco Bay Area Mental Health Education Workforce Collaborative (www.mhewc.org). A statewide collaborative now exists in Alaska (<http://www.alaska.edu/health/>) with a similar initiative underway in Arizona. While the collaboratives bring together stakeholders from diverse sectors of the behavioral health system, they are best known for bringing representatives of behavioral health together with higher education to ensure development of a pipeline of individuals sufficient in both number and skill to meet existing workforce needs.

Strategies

(a) Develop and implement a plan to establish the Behavioral Health Workforce Collaborative.

The Collaborative could be established by Governor's executive order, state inter-agency agreement, or by legislative action. Each approach has specific strengths and weaknesses. Once established, the Collaborative would replace the existing Workforce Transformation Workgroup and would be charged with strengthening the capacity of Connecticut's workforce to meet the mental health needs of all of the state's citizens. The broad definition of workforce adopted as part of this planning process would guide the focus of the Collaborative, as would the cross-system, multi-stakeholder nature of current planning efforts.

Proposed functions for the Collaborative would include, but not be limited to the following:

- Ongoing assessment and monitoring of workforce issues
- Collaboration with state agencies and private, non-profit provider organizations to develop and implement mechanisms to track the magnitude and characteristics of recruitment and retention problems
- Strategic workforce planning, with a formal, updated plan produced periodically
- Implementation of strategic plans and interventions with other stakeholders
- Coordination of workforce assessment, planning and interventions with multiple stakeholder groups
- Coordination of planning with Connecticut's higher education system on workforce supply and training content
- Educating educators about current trends in service delivery as a strategy for fostering relevant curricula in the educational system
- Working with the behavioral health, higher education, and licensing systems to improve career ladders in behavioral health within Connecticut
- Disseminating best practices in workforce development throughout the behavioral health system
- Leveraging improvement in workforce development practices through existing funding and employment mechanisms
- Advising Connecticut executive and legislative branches on workforce issues and policy
- Searching and applying for other potential sources of funds to support workforce development
- Producing a biannual report to the state on the status of the behavioral health workforce

In terms of structure, it is envisioned that there would be a fairly large and diverse General Membership Committee of the Collaborative representing, or even expanding, the diversity that currently exists within the Workforce Transformation Workgroup. Specialized task groups and/or links to other existing workgroups would be necessary to address specific topics, such as workforce needs for children, youth, and families and for persons with co-occurring mental illnesses and substance use disorders. An Executive Committee would be necessary to manage the Collaborative and its processes. Persons in recovery and parents of children and youth with emotional/behavioral problems would play a major role in all organizational structures, including the Executive Committee. To have much impact, the Collaborative would require staffing, as a volunteer committee approach to managing this process is unlikely to achieve or maintain much momentum.

Involvement/Impact on Persons in Recovery, Children, Youth, and Families

This recommendation focuses on ensuring the availability of a qualified workforce to meet the needs of consumers and families. Persons in recovery and family members would play a central role in the organization, oversight, and staffing of the Collaborative and interventions that it implements. As described below under Recommendation 2, the Collaborative would either create a task force to plan and implement a coordinated approach to fostering the role of persons in recovery and family members as part of the workforce or, alternatively, the Collaborative would link to such a planning council if it is created by the State outside of the structure of the Workforce Collaborative.

Relevance across the Lifespan

The Collaborative would specifically address workforce issues for populations across the lifespan, including children, youth, young adults, and elderly persons. Specialized task groups would address the unique workforce needs for these populations so that these needs are not lost in the general planning process.

Infrastructure

This recommendation explicitly involves the development of an infrastructure to support and conduct sustained workforce planning and development.

Measures

1. Process measures would focus on new linkages and coordinated efforts on workforce development among state agencies and between the behavioral health and higher education systems.
2. Outcome measures would be developed and assessed for specific interventions implemented by the Collaborative with other stakeholders.

Recommendation 2: Increase the number and percentage of persons in recovery and family members employed at all levels in state agencies and private, non-profit behavioral health organizations.

Need Addressed

Achieving system transformation and more resilience and recovery-oriented approaches to prevention and treatment requires much greater inclusion of the voice, perspective, and experience of adult consumers, children, youth, and family members in all efforts to care for persons with mental health problems and illnesses. While Connecticut has been a leader among

the states in forging and pursuing a vision of consumer and family-driven services, members of the Workforce Transformation Workgroup concluded that much remains to be done to translate that vision into reality. The influence of these individuals in shaping Connecticut's system of care is still far less than optimal, as evidenced by the difficulties in recruiting and retaining persons in recovery, youth, and families to participate in and to lead the planning process for the Transformation State Incentive grant.

It can be argued that dramatically increasing the roles, responsibilities, influence, and authority of these individuals is the strategic direction most likely to produce substantive transformation within Connecticut's system of services, greatly increasing the probability that consumer and family-driven care will be provided. A critical aspect of this strategic direction involves substantially increasing the number and percentage of persons in recovery, young adults, and their families who are members of the workforce. The proportion of self-identified individuals in recovery and family members currently employed in the behavioral health workforce is quite low, complicated by the fact that many staff members with mental illnesses are reluctant to disclose their illness.

Persons in recovery, youth, and family members in workforce roles are uniquely positioned to understand and address the needs of others with mental health problems and illness. From these roles they can influence the nature of services provided in the mental health system and serve as role models for clients and other staff. The research literature demonstrates that personal experience with persons who have mental illness can change personal attitudes and behavior toward this population (Wallach, 2004).

Strategies

(a) Create a standing *Planning Council on Consumer and Family Roles* to develop a coordinated approach to employment of persons in recovery and family members in the behavioral health workforce.

Critical decisions, detailed below, remain to be made about the strategies for recruiting, training, supporting, and retaining consumers and families in the workforce. In its effort to grapple with these issues, the Workforce Transformation Workgroup identified as a major concern the absence of a clear locus of planning and decision-making around consumer involvement and roles in the system, inclusive of roles in the workforce. Establishing a Planning Council to advise state agencies and private non-profit organizations on optimal policies and practices regarding consumer and family involvement should be a high priority in the transformation process. With respect to workforce roles, this Planning Council could coordinate planning and implementation efforts with the Connecticut Behavioral Health Workforce Collaborative (Recommendation 1). If the Planning Council is not created, it is recommended that a committee of the Workforce Collaborative be established to manage planning regarding consumer and family workforce roles.

(b) Establish and monitor specific objectives regarding the number and percentage of adult and young adult consumers and family members in the workforce.

Data on the number of self-identified consumers and family members in the workforce are currently unavailable in Connecticut, making planning or an assessment of progress on this objective quite difficult. DMHAS and DCF, in conjunction with the Workforce Collaborative, should establish a mechanism for tracking data on the number/percentage of self-identified consumers and family members in the workforce, set specific goals for annual increases, and track these statistics routinely. The objective to increase these rates should apply to all

administrative and clinical position types and levels, not just to entry level peer support roles. Without such data, progress in implementing this recommendation is likely to be limited. Applicable laws and personnel regulations regarding surveys of employees and their rights to keep information about their health history and status private must be fully understood and respected in this process.

(c) Develop or expand processes for recruiting, training, credentialing, supporting, developing, promoting, and retaining consumers and family members in the workforce.

Efforts to employ persons with mental health problems and their families in the behavioral health workforce have met with mixed success. A review of past efforts and interventions to strengthen future efforts is essential if this recommendation is to be successfully implemented. The Planning Council, in conjunction with the Workforce Collaborative, should clarify policies and practices regarding: recruitment (e.g., potential requirements for self-disclosure); optimal competencies, training, and orientation approaches (e.g., adoption of a peer support model such as that in Georgia, Arizona, or an alternative approach); support for consumers and families in the workforce and reasoned responses to health crises among these individuals; inclusion in the Medicaid Rehabilitation Option; requirements for credentialing; and career paths that foster promotion and leadership roles for consumers and families. It is essential to develop and implement strategies that address the culture of organizations and systems in which consumers and families are employed both to (a) ensure that these individuals become integral and vital members of the workforce, as opposed to token and marginalized employees, and (b) that desired workforce transformation takes hold and is sustained at all levels of organizational structure and operation.

Involvement/Impact on Persons in Recovery, Children, Youth, and Families

This recommendation focuses explicitly on persons in recovery, children, youth, and families. It is designed to provide them with increased options for employment within the systems that are intended to serve them. Simultaneously, it is designed to give them much greater influence over the delivery of care. As the number of these individuals in management and leadership roles increases, their influence over the organization and nature of services provided should increase substantially as well, producing the desired result of more consumer and family-driven care.

Persons in recovery and family members would play a central role in the Planning Council and in paid positions to implement strategies regarding the recruitment, training, credentialing, support, and development of their peers in the workforce.

Through employment in the mental health system, persons in recovery and family members will increase their rate of employment, earnings, personal satisfaction, and self-esteem. Adults, children and youth in treatment will be more likely to receive services that are more sensitive to their needs and will experience increased hope for recovery as their peers serve as role models. Other members of the behavioral health workforce (many of whom also are in recovery themselves, all of whom are members of families, and many of whom are parents) will see the relevance of an emphasis on recovery and resilience in their work and personal lives.

Relevance across the Lifespan

Through the employment of adults, young adults, and the family members of persons with mental health problems of all ages, this recommendation is designed to address needs across the lifespan.

Infrastructure

This recommendation is designed to change the composition of the workforce and to shift the roles and influence of consumers and families within Connecticut's system of care. These types of interventions fall within the definition of infrastructure as defined by SAMHSA

Measures

1. Process measures would focus on implementation of policies and practices to recruit, train, support, and retain consumers and family members in workforce roles.
2. Outcome measures would include growth in the number and percentage of consumers and family members employed in the workforce, as well as employment outcomes.

Recommendation 3: Increase recruitment by implementing an informational campaign that highlights career and job opportunities in behavioral health.

Need Addressed

Throughout the planning process, the Workforce Transformation Workgroup heard repeated concerns from provider organizations about their difficulties in recruiting qualified personnel to staff their programs. Specific data on the magnitude of the problem are not available since such data are not routinely collected and reported by state agencies or private non-profit providers.

However, employer feedback suggests that recruitment difficulties are acute with respect to licensed professionals (especially nurses, psychiatrists, and social workers) and culturally diverse individuals who are bilingual for all types of professional and paraprofessional positions.

Concerted strategies are needed to address these recruitment problems as the availability of a skilled workforce is an essential element of the infrastructure required to provide safe and effective care. This recommendation focuses on strategies designed to increase the pipeline of

individuals available and interested in positions in behavioral health through an informational campaign that highlights career and job opportunities in the field.

Strategies

(a) Disseminate information about career opportunities in behavioral health.

Prospective members of the workforce may be unaware of career opportunities in behavioral health or may be averse to pursuing such opportunities due to the stigma surrounding mental disorders and the stigma related to working with persons with psychological, emotional, and behavioral problems. Increasing the pipeline of individuals for the behavioral health workforce involves educating prospective students and employees about the nature of the work and career opportunities, plus educating them about mental illness in order to counter any negative attitudes that might prevent them from pursuing these opportunities.

Experience in other fields indicates that informational campaigns about career opportunities need to be targeted to individuals who have not settled on a career path. Thus, this recommendation calls for the development of informational materials and presentations targeted to high school students and to college students who are still undecided about their career path. Models exist in other states, such as California, of educational interventions in high schools. Leaders of Connecticut's higher education system, both public and private, have indicated their willingness to arrange access to college students to provide information about career opportunities in behavioral health. Special attention should be given to crafting and delivering messages tailored to persons in recovery, young adults entering the workforce, family members, and the many culturally and linguistically diverse members of Connecticut's population.

This strategy could be implemented by the Behavioral Health Workforce Collaborative (Recommendation 1) or by a Task Force, should the Collaborative not be created. The essential steps in these public relations campaigns involve: (1) clarifying the target audience; (2) crafting key messages tailored to each target audience; (3) developing the informational materials and presentations; and (4) implementing delivery of the materials to broad audiences. This strategy is focused on intermediate and long-term impact on workforce recruitment.

(b) Expand the use of on-line job posting and recruitment strategies in behavioral health.

Web-based job posting and recruitment sites are increasingly the vehicles through which prospective employees learn about job opportunities that match their interests and skills. However, these portals have not been widely used for behavioral health positions in Connecticut. The Connecticut Department of Labor (DOL) maintains a web portal for jobs within the state. In a prior initiative, DOL created a home page in this web-based system for the Department of Mental Retardation. This electronic access point has been used to foster recruitment into direct care positions in both the state-operated facilities and private non-profit organizations serving persons with mental retardation. The Workforce Transformation Workgroup recommends development of a similar web portal to the DOL site for behavioral health positions.

The Workforce Transformation Workgroup further recommends during the second year of the Transformation State Incentive grant, that plans be developed to launch a dedicated website on careers in behavioral health, linked to the DOL website and other sites that post available positions. Model websites that can guide the Connecticut effort include the Johnson & Johnson

Discover Nursing initiative (www.discovernursing.com) and the Mental Health Workforce and Education Exchange (www.mhwee.org).

Involvement/Impact on Persons in Recovery, Children, Youth, and Families

This recommendation is intended to ensure that a workforce is available in adequate numbers to meet the needs of consumers and their families in Connecticut. Further, the informational strategies will include consumers and family members as target audiences to foster their interest in and pursuit of career opportunities in this field. They will also be involved in developing and implementing the informational campaign.

Relevance across the Lifespan

Special focus will be given in the informational campaign to the unique opportunities and benefits of working with children, youth, and elderly persons. The intrinsic rewards involved in working with these populations, as well as the many opportunities that exist given the scarcity of providers trained to serve these populations, will be among the key messages of the campaign.

Infrastructure

This recommendation is designed to ensure the availability of a qualified workforce, which falls within the definition of infrastructure as defined by SAMHSA.

Measures

1. Process measures would focus on the number of individuals reached through the informational campaign and the number accessing on-line job postings for behavioral health positions.
2. Outcome measures would include the average number of funded, vacant positions in the state's system of behavioral healthcare (including state-operated and private, non-profit organizations) and the average time to fill funded vacant positions.

Recommendation 4: Increase scholarships, training stipends, and other incentives to support the recruitment and retention of culturally and linguistically diverse individuals in the workforce.

Need Addressed

The release of the U.S. Surgeon General's report, *Mental Health: Culture, Race, and Ethnicity* (U.S. Department of Health and Human Services [DHHS], 2001) and the President's New Freedom Commission on Mental Health report, *Achieving the Promise: Transforming Mental Health Care in America* (2003), highlighted the limited availability of services tailored and responsive to the individual needs, preferences, and cultural context of racial and ethnic minority communities. The significant disparities within each of these domains are evident in the fact that low-income people of minority backgrounds are able to find few, if any, mental health and addiction service programs and individual programs that practice in a manner that is congruent with their race, culture, and ethnicity. For example, survey data from the Center for Mental Health Services (DHHS, 2001) indicate that there are only 29 Latino mental health professionals for every 100,000 Latinos in the United States, compared with 173 white, non-Hispanic mental health professionals per 100,000 white, non-Hispanic persons.

Foremost among these disparities is the relative absence of providers who can render culturally competent services to these populations. While Connecticut has been responding to a recognized need to develop the cultural competence of the entire workforce, there is an urgent need to bring more culturally and linguistically diverse individuals into the workforce. This can be accomplished through the use of targeted incentives to encourage and support such individuals in pursuing careers and jobs in behavioral health. Such incentives have been used successfully across the nation, particularly to support such individuals entering graduate training in behavioral health.

Strategies

(a) Develop and implement a detailed plan regarding the types of incentives, eligible candidates, and mechanisms for selecting recipients.

As a first step, this recommendation requires a thorough review of the existing incentives and their impact within Connecticut. This review would inform the development of an implementation plan to expand incentives to culturally and linguistically diverse populations. The target groups should be diverse, with incentives tailored to their unique characteristics and needs. Potential target groups and incentives include the following: mentored field experiences for high school students; scholarships to support participation in behavioral health certificate, associate, undergraduate, and graduate behavioral health programs; sign-on bonuses for employment in the state's behavioral health system; support for continuing education and participation in leadership development programs; and salary enhancements tied to educational advancement.

As part of this effort, information about federally-funded supports for culturally and linguistically diverse populations should be assembled and broadly disseminated so that Connecticut maximizes the use of these resources. Examples include initiatives such as the National Institutes of Health and the National Health Services Corps Loan Repayment Programs.

Involvement/Impact on Persons in Recovery, Children, Youth, and Families

This recommendation is specifically focused on ensuring that adults in recovery, children, youth and families of diverse backgrounds have direct and timely access to providers capable of delivering care that is culturally and linguistically relevant. A portion of the incentives would be targeted to persons of color who are also consumers and family members as part of the effort, outlined in Recommendation 2 to significantly expand the number of such persons employed in the workforce.

Relevance across the Lifespan

The use of incentives is broadly applicable to recruiting personnel to work with all populations across the life span. As Connecticut assesses critical workforce shortage areas, such as skilled personnel to treat children and elderly persons, it can target incentives specifically to these needs.

Infrastructure

This recommendation is designed to ensure a workforce capable of meeting the needs of Connecticut's culturally diverse population. As such, it falls within the definition of infrastructure outlined by SAMHSA.

Measures

1. Process measures would focus on the expansion of incentives programs for culturally and linguistically diverse individuals to enter the behavioral health workforce.
2. Outcome measures would include the number and percentage of culturally and linguistically diverse individuals employed in Connecticut's behavioral health system and the number supported through incentives to enter the workforce/employment.

Recommendation 5: Develop a workforce skilled in caring for children, youth, and families by identifying core competencies and implementing competency-based curricula focused on the needs of these individuals.

Need Addressed

In focus groups conducted throughout the state, concern was expressed about the competence of the behavioral health workforce, particularly with respect to the care of children, youth, and their families. Competence was defined to include not only the ability to deliver high quality traditional clinical services, but more broadly, to include issues such as an appreciation and respect for consumers and families, an awareness of and ability to link to available resources, and effective collaboration on behalf of children, youth, and families in coordinated, community-based systems of care. This concern about competence extended not only to those involved in traditional behavioral health service delivery, but also to members of the broadly-defined behavioral health workforce including, for example, teachers and primary healthcare providers. This recommendation focuses on the need to achieve greater clarity and specificity in the optimal competencies for the behavioral health practice care of children, youth, and families, and to incorporate these competencies into workforce training efforts.

Strategies

(a) Identify core competencies for behavioral health practice with children, youth, and families; incorporate these competencies into existing curricula and/or develop new curricula based on these competencies; and implement these curricula in pre-service and continuing education programs.

This initiative focuses on the behavioral healthcare of children and youth, building upon competency development work that has been previously completed or is currently underway in the State of Connecticut. A set of core competencies required to respond appropriately to the behavioral health needs of children and families and promote social and emotional development will be developed and published. This set of core competencies will include a foundation of competencies common to all members of the behavioral health workforce (broadly defined to include professionals and paraprofessionals providing behavioral health services, as well as educators, primary care physicians, juvenile justice personnel, and others involved in the care of children and families with behavioral health needs). Building upon this common foundation, additional specific competencies will be identified that pertain to each subgroup within the behavioral health workforce.

Significant work regarding the identification of core competencies was undertaken in conjunction with DCF's KidCare initiative. This previous work will provide a foundation on which the current initiative will build. An organization will be identified or a special task force established to facilitate the collaboration of consumers, families, behavioral healthcare providers, educators, state agency representatives, and others in this effort. Possible resources for this effort could include the proposed Behavioral Health Workforce Collaborative (Recommendation 1), the Children's Behavioral Health Advisory Council, the Connecticut Center for Effective

Practice of the Child Health and Development Institute, and various state agency training academies.

In line with the identified core competencies, a curriculum-based training and supervision program will be developed and implemented. This training will be provided both to current members of the broadly-defined behavioral health workforce as well as to those preparing to enter the workforce (e.g., graduate students in Medicine, Psychology, Social Work, Education, etc.). Here, as above, efforts will build upon work already undertaken. For example, DCF has been collaborating with providers and institutions of higher education in the development of a curriculum regarding the delivery of intensive home-based services using evidence-based and promising practices. The intent is that this curriculum will be implemented in programs such as Social Work graduate training and be coordinated with a program of supervised practicum placements in agencies across Connecticut using this service model.

Involvement/Impact on Persons in Recovery, Children, Youth, and Families

This recommendation stemmed in large part from comments made by consumers and family members, in particular by parents of children and youth with behavioral health needs. It is intended that consumers and family members will represent a significant percentage of individuals participating in the process of core competency identification and curriculum development. Moreover, consumers and family members will be asked to participate in the instructional component of this initiative, offering “first-hand” knowledge and experience of issues confronted in the behavioral healthcare system by children, youth, and family members. In this way, it is expected that members of the behavioral health workforce will develop an

enhanced understanding of the strengths and needs of children, youth, and their families and that this will better equip them to perform their respective roles in a manner that is authentically consumer and family driven.

Relevance across the Lifespan

This recommendation addresses core competencies common to the behavioral healthcare of individuals across all segments of the lifespan spectrum, as well as essential competencies specific to the behavioral healthcare of young children, school-age children, adolescents, and their families. A primary objective of this initiative is to better equip the behavioral health workforce to understand and appreciate the needs unique to individuals across different segments of the lifespan and to deliver services in a manner that is responsive to these needs.

Infrastructure

The focus of this recommendation is to establish a commonly accepted set of competencies and a related set of competency-based curricula. Thus, the interventions will create an improved training infrastructure and a more skilled workforce. These types of interventions fall within the definition of infrastructure development provided by SAMHSA.

Measures

1. Process measures relate to the inclusion of youth and families in developing competencies and curriculum and the incorporation of competencies into pre-service and continuing education training programs.

2. Outcome measures relate to the number of providers trained to provide services to children, youth, and families, as well as competency assessments and other personnel evaluations of individuals who have participated in competency-based training.

Recommendation 6: Develop and deliver recovery-oriented, culturally informed, and gender responsive training on mental illness and co-occurring disorders to (a) direct care, paraprofessional personnel in the behavioral health system; and (b) other health and human service personnel who are not part of the specialty behavioral health workforce.

Need Addressed

Focus groups and individual interview findings consistently emphasized the need for knowledge and skill development among the workforce. Within behavioral health systems this is particularly, although not exclusively, a concern for entry level, direct care staff who do not have formal graduate training or other preparation for this work. As the economic health of behavioral health organizations has worsened, it has become increasingly difficult to provide release time to these employees for the offsite orientation and training programs that were historically provided by state agencies such as DMHAS. As a result, many of the services provided in the public sector may be delivered by individuals who have little knowledge about mental illnesses and co-occurring substance use disorders or effective treatment approaches. There is an acute need for flexible, accessible, and competency-based training approaches to meet the needs of this segment of the workforce.

Similarly, there are a large number of other health and human service personnel who are not part of the specialty behavioral health workforce, but who routinely respond to the needs of persons with mental illnesses, behavioral/emotional problems, and co-occurring addictive disorders.

These include, but are not limited to: employees in state service, such as those within the

Department of Labor, Department of Corrections, and the Court Support Services Division of the Judicial Branch; primary care providers, teachers and other school personnel; and emergency department staff. There is a need to provide accessible basic training to these segments of the workforce as well. It is abundantly clear from the research literature on access to care that individuals more often seek help for mental and addictive disorders outside of the specialty behavioral health system than from within it.

Strategies

(a) Identify or develop core competencies and competency-based training curricula tailored to the needs of entry-level direct care behavioral health providers and other health and human service personnel.

Previous work has occurred within Connecticut and nationally on competency identification and curriculum development for these segments of the workforce. NAMI's 10-session Provider Education Program, developed nationally and implemented locally by NAMI Connecticut, stands as one noteworthy example. Further work is required to identify the unique training needs of entry-level behavioral health providers and other health and human service personnel. This must be followed by efforts to access the relevant resources that could be adopted and adapted to meet these training needs, with additional competency identification and curriculum development occurring as necessary.

The core competencies and related curricula must encompass the basics regarding these illnesses and related treatments; co-occurring disorders; resilience and recovery-oriented approaches to care; needs across the lifespan; person-centered planning; evidence-based practices; and the provision of culturally relevant and gender responsive care, to name just a few key topics. For

other health and human service personnel there must be an emphasis on basic interventions plus strategies for accessing consultation or making successful referrals.

(b) Develop and implement evidence-based training strategies that are accessible to these segments of the workforce.

The second major task involves developing and implementing strategies to provide the training. These strategies must draw on evidence-based teaching principles, as most training efforts with these workforce segments use single session, didactic approaches that have been proven through controlled research to be ineffective. Simultaneously, these selected strategies must be affordable and accessible, working within the constraints of employer organizations that do not have the luxury of providing large amounts of release time to each employee. Serious consideration should be given to the use of computer-assisted instruction as one element of the teaching approach, which is discussed in more detail in the section on Recommendation 7.

Training approaches should involve persons in recovery, youth with emotional/behavioral problems, and family members as faculty, educating the workforce about mental health problems and illnesses, the lived experience of these problems, and the consumer/family perspective on treatment and treatment systems. These direct contacts have the potential to impact positively on negative attitudes that may be held by members of the workforce about persons living with these illnesses. This training approach is also an excellent vehicle for teaching about the concepts of resilience and recovery. Implementation of this recommendation could be managed by the Behavioral Health Workforce Collaborative, a specially convened task force, or by the training divisions within DMHAS and DCF, provided that additional resources were provided to these divisions.

Involvement/Impact on Persons in Recovery, Children, Youth, and Families

Increasing the competencies (attitudes, skills, and behaviors) of workforce members, both behavioral and non behavioral specialty, will improve the quality and effectiveness of services available to individuals in recovery, whether children, youth and/or adults and their families. It will deepen the knowledge base from which staff work and will also enhance understanding of the experience of mental illness, co-occurring disorders, and the processes of recovery, self-empowerment, and personal choice. Inclusion of persons in recovery and families as faculty will enrich the content and process of learning for all participants and counter the all too prevalent stigmatizing attitudes regarding persons with these illnesses.

Relevance across the Lifespan

The needs of persons with mental illnesses and co-occurring disorders and their families change and evolve over the lifespan. It is essential that basic training include components focused on children, youth, adults, and older people, and the impact of development on needs. Further, the recommendation to train entry level direct care personnel and other health and human service providers is a cross-cutting issue that has relevance to healthcare sectors that serve different age groups in Connecticut.

Infrastructure

The focus of this recommendation is on developing a workforce capable of meeting the needs of persons with mental health problems and illnesses. This falls within the definition of infrastructure development as defined by SAMHSA.

Measures

1. Process measures include the volume of training provided to behavioral health providers and other health and human service personnel.
2. Outcome measures would involve competency assessments and other evaluations of individuals who received the training.

Recommendation 7: Implement a system to provide web-based training to the specialty workforce, other health and human service personnel, persons in recovery, children, youth, and families.

Need Addressed

There has been a dramatic expansion in many fields in the use of web-based learning to provide training and education. The relatively low cost and broad access that this approach affords makes it an attractive method for potentially reaching large numbers of individuals. Its application in behavioral health has been growing steadily, although face-to-face didactic instruction remains the mainstay of training approaches. Questions remain about the effectiveness of achieving skill acquisition through web-based instruction or, more precisely, what types of experiential learning and supervision must be combined with this approach to ensure skill development.

The rationale for increasing the utilization of web-based learning in behavioral health in Connecticut is, nevertheless, quite compelling. Standardized, competency-based instruction of high quality must become much more available and accessible to this state's workforce and this is unlikely to be accomplished without the aid of various electronic supports. No robust and flexible electronic platform for web-based instruction is readily available to state agencies and

their grantees to support computer assisted and distance learning. The Workforce Transformation Workgroup concluded that this is a substantial need that should be addressed, in part, through the Transformation State Incentive Grant.

Strategies

(a) Select the platform that will be used to support web-based training for the behavioral health workforce.

The behavioral health community cannot afford to develop and support a stand-alone electronic platform to meet this need. Fortunately, two potential options described below can be explored that would involve a partnership between the behavioral health system and other state agencies through the initiative of DOIT, as well as an already-existing distance learning consortium.

The Department of Information Technology (DOIT) is currently exploring the feasibility of creating a shared, inter-agency platform that would support web-based instruction for participating state agencies and their grantees. Potential vendors have responded to a Request for Qualifications and a team of state representatives is evaluating the products and services of respondents. The sharing of costs across state agencies would minimize costs for each participating agency. Additional resources would be required to develop and manage mental health-related content on the site. A decision by DOIT on proceeding with this initiative is expected in late 2006.

Currently existing is the Connecticut Distance Learning Consortium (www.ctdlc.org). This is a state entity that provides an on-line learning platform, courses, services, and supports for all public institutions of higher education in Connecticut and all but one private institution. The

Consortium's services, which include the electronic platform and consultation on content development, are available for purchase by any other private or non-profit business in the state. Representatives of the higher education community are quite positive about the professionalism, effectiveness, and cost efficiency of this Consortium, which could support the mental health community.

(b) Develop and implement a comprehensive plan to deliver training via the Web.

The Workforce Transformation Workgroup recommends that a platform for supporting web-based learning in behavioral health be selected in Federal Fiscal Year 2007. Behavioral health curricula could be developed and pilot-tested during this same year as a comprehensive plan for use of this system is developed. Full scale implementation would then occur in FY 2008. The selection, piloting, and implementation could be managed by the Behavioral Health Workforce Collaborative, a special task force, or the training departments of Connecticut's state agencies.

Involvement/Impact on Persons in Recovery, Children, Youth, and Families

This recommendation is intended to improve the training and skill level of the workforce engaged to serve persons with mental illnesses or behavioral/emotional problems. The electronic platform would be used to provide education to consumers and families, in addition to the specialty workforce. The Workforce Transformation Workgroup notes that Connecticut is in the process of attempting to purchase a web-based information system for consumers, family members, and providers, such as that offered by Network of Care (www.networkofcare.org). The workgroup strongly endorses this action as it will make information about mental illnesses

and service resources widely available to all Connecticut citizens, with particular relevance for consumers and family members.

Relevance across the Lifespan

As a tool, web-based learning is equally applicable to workforce needs across the life span of populations served by the workforce. It may be particularly useful in increasing exposure of the workforce to the needs and treatment approaches for children, youth, and elderly persons, as these topic areas are under-represented in traditional training and education systems.

Infrastructure

This recommendation explicitly focuses on the development of an infrastructure to support training and education of the workforce.

Measures

1. Process measures include the amount of curricula available on-line and the amount of training conducted using this infrastructure.
2. Outcome measures include the resulting competencies of individuals participating in web-based instruction.

Recommendation 8: Ensure that all members of the workforce receive high quality supervision in accord with a common set of standards from individuals trained in competency-based supervision.

Need Addressed

Participants in the focus groups and interviews conducted as part of this planning process consistently identified the lack of supervision regarding the provision of care as a critical behavioral healthcare workforce problem. Direct care staff, program managers, and agency leaders all expressed concerns about insufficient training of supervisors and variable organizational support for supervision. They also decried the lack of time available within organizations to devote to this important activity due to high levels of service demand and severe economic constraints. While most members of the workforce desire a greater emphasis on supervision, competing agendas, such as high caseloads and productivity demands, were consistently viewed as obstacles.

There was considerable debate within the Workforce Transformation Workgroup about the essential elements of supervision. Currently, there appears to be a heavy emphasis within behavioral health organizations in Connecticut on “administrative” supervision that is limited to ensuring employee compliance with work rules, documentation, and billing requirements. One member of the workgroup described the typical approach to supervision as constituting “surveillance” of employees, rather than substantive supervision. There was strong support for strengthening supervision of the services and care provided to consumers and family members and for enhancing the mentoring and professional development focus that should be a cornerstone of supervisory relationships. Training supervisors in supervisory skills was

considered an essential strategy, as many of these individuals report never having received such training and being uncomfortable with many aspects of the supervisory process.

Skilled supervisors and effective supervision were viewed by the Workforce Transformation Workgroup as critical to ensuring safe and effective care and as essential lynchpins in the transformation process. Staff training in evidence-based, recovery, and resilience-oriented approaches to care is unlikely to result in sustained changes in workforce practice patterns unless supervisors understand these treatment approaches and foster their adoption through sustained supervision. Of all the issues considered by the Workforce Transformation Workgroup, the need to strengthen supervision was the recommendation most frequently endorsed and it represents the area of greatest consensus emerging from this process.

Strategies

(a) Ensure that all current and new supervisors in the behavioral health system receive formal, competency-based training on supervision, followed by periodic continuing education focused on these skills.

Staff members tend to be promoted to supervisory positions because of their effectiveness and efficiency as direct care staff. They may have few supervisory skills when first promoted into this role and, unfortunately, few appear to receive structured training or mentoring regarding these new responsibilities. Training in supervisory knowledge, attitudes, and skills should begin as individuals assume these roles. Supervisors report that having the necessary skills at the initiation of the supervisory relationship greatly fosters the effectiveness of the process.

Ensuring that supervisory training occurs requires the development of systems within human resource departments of state and private, non-profit agencies to track the initial training and

continuing education of supervisory personnel. The optimal competencies of supervisors for Connecticut's behavioral health system also must be clarified. This task can be informed by efforts within DCF to identify supervisory competencies for its child protective workers and by national efforts funded by the Center for Substance Abuse Treatment (CSAT) to identify supervisory competencies for addiction counselors. Curricula and training modules on supervision that can be used within Connecticut to implement this recommendation must be identified and reviewed to ensure that they are competency based. Persons in recovery and families should be involved in the development of curriculum content and process. The training must be provided using evidence-based teaching principles, which call for interactive and continuous learning, rather than didactic single session/lesson approaches. Continuing education must help supervisors develop the more complex people management skills once the basics are mastered.

(b) Ensure that all members of the workforce receive high quality supervision in accord with a common set of standards specifying minimum frequency and intensity.

Previous efforts in Connecticut indicate that supervision patterns are unlikely to change unless there are accepted standards monitored for compliance regarding the provision of supervision. . The Workforce Transformation Workgroup recommended that standards be created specifying the minimum frequency, intensity, and modality (e.g., individual and group) of supervision for different classes of employees (e.g., unlicensed, direct care provider; licensed professional). Intensive, competency-based supervisory training should be offered to organizations that agree to adopt these standards and implement systems to track compliance with these standards. Also to be developed are mechanisms for assessing the quality of supervision provided, with a strong emphasis on satisfaction with supervision as reported by supervisees.

Implementation of this recommendation could be managed by the Behavioral Health Workforce Collaborative or by a special task force on supervision, with persons in recovery and families included as members. A detailed implementation plan would be developed, followed by work on competency identification, refinement of training curricula, standards for supervision, and strategies for assessing the quality of supervision. It is recommended that the training and monitoring be piloted in selected work environments, refined based on experience, and then made more broadly available to the behavioral health workforce across the State. Achieving a skilled supervisory workforce and the desired *culture of supervision* cannot be accomplished through a few quick training sessions. Focused efforts in a more limited number of work settings with the development of an approach that is exportable to other settings are highly preferable to scattered and limited efforts to impact the whole system in a superficial and ineffective manner.

Involvement/Impact on Persons in Recovery, Children, Youth, and Families

Competent supervision is essential to the provision of safe and effective services and to the entire process of transformation. To the extent that better supervision leads to service improvement, persons in recovery, children, youth, and families will directly benefit. These individuals would also play an integral role in workgroups designed to implement this recommendation, thereby influencing the supervisory competencies, curricula, standards, and quality measurement strategies adopted. Additionally, they can assist in identifying the optimal focus within supervision that, in their view, can lead to improved staff performance (e.g., person-centered planning; shared decision-making; health and wellness promotion; empowerment strategies; cultural competence). Training and development of supervisors will also have direct relevance in

peer-operated agencies or programs where the basic principles of supervision have equal applicability and the potential to improve the safety and quality of services provided.

Relevance across the Lifespan

Supervision is a behavioral health workforce issue relevant to populations across the lifespan. This recommendation can be implemented within programs and agencies that serve children, youth, young adults, adults, and elderly persons. The capacity to assess and address developmental issues will be represented in the supervision competencies, fostering the ability of supervisors to help their staff better address needs across the lifespan and provide age appropriate services.

Infrastructure

This recommendation focuses on creating an infrastructure in which the development of competencies, curricula, standards, tracking systems, quality assessment procedures, will result, most importantly, in a cadre of skilled supervisors who can ensure the safety, relevance, and effectiveness of behavioral healthcare.

Measures

1. Process measures include the number/percentage of supervisors who have received competency-based training.
2. Outcome measures would focus on the volume of supervision provided, compliance with supervision standards, and ratings of supervision quality by supervisees.

Recommendation 9: Develop “Centers for Excellence” in behavioral health workforce practices. This initiative will begin in the child and youth behavioral health arena and subsequently be expanded to encompass youth in transition to adulthood, adult persons in recovery, and older adults.

Need Addressed

The challenges facing the traditional behavioral health workforce are numerous, both in terms of the ability to recruit and retain sufficient numbers of competent staff as well as the ability of these staff to deliver care in a manner consistent with current best practices. These workforce challenges create limitations regarding access to care and quality of care. Further, they result in job dissatisfaction and low morale on the part of many behavioral healthcare staff. This recommendation focuses on creating Centers for Excellence that can serve as resources and models for other organizations about best practices in workforce development.

Strategies

(a) Fund selected organizations to serve as behavioral health workforce Centers for Excellence, implementing best practices in recruitment, retention, and training. Establish mechanisms for these Centers to disseminate the best practices to other organizations.

This initiative will begin in the child and youth behavioral health arena and subsequently be expanded to the areas of transitional youth, adult persons in recovery, and older adults.

Regional "Centers of Excellence" would be established in existing agencies that provide behavioral health services to children, youth, and their families. These Centers of Excellence would serve as models for workforce development with regard to: recruitment, retention, opportunities for staff advancement, training, supervision, and implementation of best practices in health promotion, prevention, and treatment.

These Centers of Excellence will be expected to serve as regional resources of expertise and consultation for other Connecticut behavioral health service providers, offering training and technical assistance in workforce development and the implementation of best practices.

This initiative would be piloted with funds from the Transformation Grant. To sustain this concept at the conclusion of the grant, financing models would be developed and proposed that would provide increased reimbursement levels to these Centers through the Connecticut Behavioral Health Partnership and/or augmentation of state grant support.

This financing model is informed by and expands on a plan currently being implemented by the Connecticut Behavioral Health Partnership. Community-based Enhanced Care Clinics have been established, providing care that is required to meet higher benchmarks in areas such as facilitation of peer support, coordination with primary care, ability to deliver care for co-occurring (substance abuse and mental health) conditions, and timely access to care. The ability to consistently meet these higher benchmarks is tied to an enhanced rate of reimbursement for clinical services (currently a 25% increase).

Involvement/Impact on Persons in Recovery, Children, Youth, and Families

One of the core components of practice within a proposed Center of Excellence would be the meaningful involvement of consumers and family members in care delivery, through positions such as Family Advocate or Peer Support Specialist or other standard administrative or clinical positions within an agency. It would be expected that individuals in these roles would have the opportunity and the responsibility to advise the behavioral healthcare agency regarding consumer

and family driven care and have meaningful involvement in shaping agency policy to achieve these desired outcomes.

Relevance across the Lifespan

This initiative will be aimed at improving the quality of behavioral healthcare delivered to individuals across all segments of the lifespan spectrum. The first phase of the initiative will pertain to the child and youth behavioral health arena, and will subsequently be expanded to the areas of transitional youth, adult persons in recovery, and older adults. Priority in funding such Centers might be given to agencies that provide care to populations across the lifespan.

Infrastructure

This recommendation focuses on establishing an infrastructure of Centers that excel in effective workforce development practices and export these practices to other organizations.

Measures

1. Process measures would include the implementation of workforce development best practices in the Centers for Excellence and consultation volume with other organizations.
2. Outcome measures would focus on staff turnover rates, staff satisfaction with job and career, and consumer/family satisfaction with services received.

Conclusion

A diverse group of individuals representing persons in recovery, family members, state agencies, private non-profit providers, educators, researchers and workforce experts has completed an

intensive process of workforce planning during the past five months. This group shared a strongly held conviction that strengthening the behavioral health workforce should be among the highest of priorities as the State of Connecticut strives to transform its system of mental healthcare. The vast majority of behavioral health resources are its *human* resources and these must be developed, nurtured, and supported if access to care and quality of care are to be substantially improved.

It is *imperative* that the State intensify efforts to recruit and retain individuals who are committed to providing compassionate and effective care to persons with mental illnesses, while achieving within the workforce greater cultural and linguistic diversity and a much greater role for persons in recovery and family members. It is *imperative* that the State provide continuous, competency-based education and staff development opportunities for this workforce, utilizing effective teaching strategies and reaching those members of the workforce who currently receive little, if any training. Finally, it is *imperative* that those providing mental health services routinely receive skilled supervision and that permanent structures be put in place to promote a sustained workforce planning and development agenda. Mental health transformation requires workforce transformation. The recommendations outlined in this report are offered as essential next steps toward achieving these transformation goals.

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